City of Falls Church
Emergency Care Information

In case of an emergency, the camp staff will contact 911. Every attempt will be made to contact a parent/guardian or a designated emergency contact.

Camper Name: _____ _____ _____ Last First Middle			
Name of Camp:	Date of Birth:	Sex: ☐ M ☐ F	Grade as of September 2010:
Language Spoken at Home:	Student resides with: ☐ Father, ☐ Mother, ☐ Both, ☐ Legal Guardian		
FATHER's Name (Last, First and Middle)		Home ( )	
FATHER's Address:		Work ( )	
		Pager/Cell ( )	
MOTHER's Name (Last, First and Middle)		Home ( )	
MOTHER's Address:		Work ( )	
		Pager/Cell ( )	
LEGAL GUARDIAN's Name (Last, First and Middle)		Home ( )	
GUARDIAN's Address:		Work ( )	
		Pager/Cell ( )	

LIST 2 LOCAL PERSONS WE SHOULD CALL IN AN EMERGENCY IF THE PARENT/GUARDIAN CANNONT BE REACHED:

Name of Person	Relationship	Telephone
1.		( )
2.		( )

LIST ADDITIONAL INDIVIDUALS AUTHORIZED TO PICK UP YOUR CHILD:

NAME: RELATIONSHIP:

NAME: RELATIONSHIP:

ADDITIONAL INFORMATION

Name of Health Insurance Company		Name of Student's Physician
Policy/Group/Employee Number	HMO Number, if applicable	Physician's Telephone ( )

MEDICAL INFORMATION

Check any current health condition that may require attention during the camp day.

How do medical and/or health conditions affect you child's day?

☐ None
☐ Allergies (be specific)
☐ Foods _____
☐ Medicines _____
☐ Bee Sting/Insect_____
☐ Asthma
☐ Diabetes
☐ Hearing Problems ☐ Hearing Aid(s)
☐ Heart Problems (be specific) _____
_____
☐ Hemophilia
☐ Physical Disability (be specific) _____
☐ Respiratory (be specific) _____
☐ Seizures

List all medications and dosages you child receives on a continual basis: _____
_____

Is medication required during camp hours?
☐ Yes If yes, complete medical forms
☐ No

Others (be specific): _____
_____
_____
_____

Special Procedure: _____
_____
_____

The camp has my permission, in an emergency when I cannot by contacted, to take my child to the emergency room of the nearest hospital and its medical staff have my authorization to provide treatment which a physician deems necessary for the well-being of my child.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

Return this form by June 1, 2010 to:

Amy Maltese – Falls Church Community Center
223 Little Falls Street – Falls Church, VA 22046